Montana Department of Public Health and Human Services

West Nile Viral Illness Reporting Form

PATIENT INFORMATION

Name:			DOB:
Age:	Sex: □ M □ F	Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Hispanic ☐ Unk	
Address:			Phone:
City:	County:		Zip:

CLINICAL INFORMATION

Date of Illness Onset:	**Neuro-invasive Illness:** **□Yes □No □Unk**	**Febrile Illness:** **□Yes □No □Unk**
Hospitalized: ☐ Yes ☐ No	Encephalitis: □Yes □No □Unk	Fever (∃38EC or100EF): □Yes □No □Unk
Hospital Name:	Meningitis: □Yes □No □Unk	Headache: □Yes □No □Unk
Date of Admission:	Stiff neck/Meningeal signs: □Yes □No □Unk	Fatigue: □Yes □No □Unk
Discharge Date:	Seizures: □Yes □No □Unk	Rash: □Yes □No □Unk
Health Care Provider:	Altered Mental Status: □Yes □No □Unk	Swollen Lymph Nodes: □Yes □No □Unk
Phone:	Other neurological signs: □Yes □No □Unk	Eye Pain: □Yes □No □Unk
Date Reported to Local Health Department::	**Outcome:** ☐ **Recovered** ☐ **Still ill** □ **Deceased** ☐ **Unk**	
	Date of Death:	

LABORATORY INFORMATION

Date Lab Specimen Collected:	Testing Laboratory:
Specimen Source: ☐ Blood ☐ CSF ☐ Other ***(List below)***	IgM: ☐ pos ☐ neg ☐ equiv IgG: ☐ pos ☐ neg ☐ equiv ***(Please attach lab report(s) if available.)***

OUT OF STATE TRAVEL HISTORY

Travel outside Montana 14 days prior to illness onset? ☐ Yes ☐ No ☐ Unk	Location(s):	Dates:

COUNTY HEALTH DEPARTMENT USE ONLY

☐ New Case ☐ Update of prior report	Out of Jurisdiction Case. Case was: ☐ Referred to DPHHS ☐ Referred to County of Residence
Comments:	
Local Health Department Reviewer:	Date:

Additional Questions to Assess Underlying Medical Conditions and Medication Use

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

Diabetes	□ Yes	□ No	□ Unknown
High blood pressure (hypertension)	□ Yes	□ No	□ Unknown
Heart attack (myocardial infarction)	□ Yes	□ No	□ Unknown
Angina or coronary artery disease	□ Yes	□ No	□ Unknown
Congestive heart failure (CHF)	□ Yes	□ No	□ Unknown
Stroke	□ Yes	□ No	□ Unknown
Chronic obstructive pulmonary disease (COPD)	□ Yes	□ No	□ Unknown
Chronic liver disease	□ Yes	□ No	□ Unknown
Kidney disease or failure	□ Yes	□ No	□ Unknown
Alcoholism	□ Yes	□ No	□ Unknown
Bone marrow transplant	□ Yes	□ No	□ Unknown
Solid organ transplant	□ Yes	□ No	□ Unknown

If yes: What organ was transplanted?: _____
What year was the transplant?: _____

Cancer □ Yes □ No □ Unknown

If yes: What type(s)?: _____
What year were you diagnosed?: _____
Are you currently being treated for cancer?: □ Yes □ No □ Unknown

2. Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection? □ Yes □ No □ Unknown

If yes: What condition(s)?: _____

3. At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?

Chemotherapy	□ Yes	□ No	□ Unknown
Other treatments for cancer	□ Yes	□ No	□ Unknown
Hemodialysis	□ Yes	□ No	□ Unknown
Other treatments for kidney disease	□ Yes	□ No	□ Unknown
Oral or injected steroids	□ Yes	□ No	□ Unknown
Inhaled steroids	□ Yes	□ No	□ Unknown
Insulin or other medications to treat diabetes	□ Yes	□ No	□ Unknown
Medications to treat high blood pressure	□ Yes	□ No	□ Unknown
Medications to treat coronary artery disease	□ Yes	□ No	□ Unknown
Medications to treat congestive heart failure	□ Yes	□ No	□ Unknown
Medications that suppress the immune system	□ Yes	□ No	□ Unknown

4. Which of the following sources provided the information above?

Patient	□ Yes	□ No	Family member/friend	□ Yes	□ No
Provider	□ Yes	□ No	Medical record	□ Yes	□ No